

## Adult/Dislocated Worker

UserID:

VOS

LWIA:

AppID:

SSN:

Name:

Date of Application:

Address 1:

Address 2:

City, State, Zip:

County:

Primary Phone:

### Alternate Contact Information:

Contact Name:

Contact Address 1:

Contact Address 2:

Contact City, State Zip:

Contact Phone:

Relationship:

### Personal Information:

Gender: -

Date of Birth:

Age:

Selective Service: -

Citizenship: -

### Ethnicity/Race:

Hispanic:

Race:

### Disability:

Disabled:

Disabled Substantially  
Affects Employment:

### Veteran Information:

Served in the Military:

Disabled Vet: -

Campaign Vet:

Recently Separated:

Employment Information:

Are you Employed:

Current hourly rate:

Receiving UC:

-

-

If employed, under - employed:

Termination / Layoff:

Received a termination or layoff notice  
from last job or job of dislocation:

Actual:

Layoff  
Date

Reason for Layoff:

OR

Projected:

Layoff  
Date

Dislocation Employer Name:

Address 1:

Address 2:

City, State Zip:

Dislocation hourly rate:

Attend Group Orientation:

Dislocation Event:

Barriers:

Core and Intensive Application:

Displaced Homemaker:

Core and Intensive Application:

Has limited reading, speaking, writing or understanding of the  
English language - is English a second language:

Single Parent:

Homeless:

Offender

Education:

Highest Grade Completed:

Public Assistance:  
- Intensive Services Application Only -

Receiving TANF

Receiving SSI

Receiving Refugee Assistance:

Receiving Food Stamps:

Receiving General Assistance:

Receiving or been notified will receive any Pell Grant monies:

Income Information:  
- Intensive Services Application Only -

Family of One:

Number in Family:

Family Income

Low Income:

Eligibility:

LWIA Priority for Services policy:

Meets the LWIA Adult Priority for Service definition:

Considered "Not Self Sufficient" based on LWIA definition:

Adult Eligible:

Dislocated Worker Eligible:

Statewide Program Eligibility

Statewide **Displaced Homemaker - Adult:**

Statewide **Displaced Homemaker - Dislocated Worker:**

Statewide **Other - Adult:**

Statewide **Other - Dislocated Worker:**

Statewide **Incumbent Worker:**

Statewide **Rapid Response Additional Assistance:**

Core Eligibility Date:  
Date Core is fully documented

Intensive Eligibility Date:  
Date Intensive is fully documented

Eligibility Contractor:

Staff Name:

Comments

Signature of Staff Person

Date

One Stop Center

Applicant Certification Statement: *(Not to be signed and dated until all documentation has been provided.)*

I certify that the information on this application is accurate to the best of my knowledge. I understand that my willful misstatement of the facts may cause my forfeiture of rights in the WIA Program and may result in criminal action. I give permission for outside sources to be contacted and for them to disclose any information necessary to verify my eligibility for WIA. I further understand and agree that my social security number and other information on this application will be provided to other government agencies if required by law.

Signature of Applicant

Date

Signature of Guardian

Date

Record Review:

Review Date:

Review Staff Name:

Met Requirements:

Printed Date:

Record Created Dat

Record Edited Date: